Appendix P
Colorado Medical Assistance Program
Prior Authorization Procedures and Criteria and Quantity Limits
For Physicians and Pharmacists

Drugs requiring a prior authorization are listed in this document. The Prior Authorization criteria are based on FDA approved indications, CMS approved compendia, and peer-reviewed medical literature.

Prior Authorization Request (PAR) Process

- Products qualify for a 3 day emergency supply. In an emergency situation call the help desk for an override.
- Pharmacy PA forms are available by visiting: https://www.colorado.gov/hcpf/provider-forms
- PA forms can be signed by anyone who has authority under Colorado law to prescribe the medication. Assistants of authorized persons cannot sign the PA form
- Physicians or assistants who are acting as the agents of the physicians can request a PA by phone
- Pharmacists from long-term-care pharmacies and infusion pharmacy must obtain a signature from someone who is authorized to prescribe drugs before they submit PA forms
- Pharmacists from long-term-care pharmacies and infusion pharmacies can request a PA by phone if specified in the criteria
- All PA's are coded online into the PA system
- Prior Authorizations can be called or faxed to the helpdesk at:
  Phone: 1-800-365-4944
  Fax: 1-888-772-9696
- As of July 1, 2007, ICD-9 codes can be submitted in the point-of-sale system to override certain prior authorizations. To verify an ICD-9 code contact the PAR Helpdesk at:
  Phone: 1-800-365-4944
- Non-narcotic prescriptions may be refilled after 75% of previous fill is used. Narcotic prescriptions may be refilled after 85% of the previous fill is used. Synagis may be refilled after 92.5% of the previous fill is used.

Medical Supply Items and Medications

- All supplies, including insulin needles, food supplements and diabetic supplies are not covered under the pharmacy benefit, but are covered as medical supply items through Durable Medical Equipment (DME)
- If a medical benefit requires a PA, the PA request can be submitted through the provider application available at: http://www.coloradopar.com/carewebqi/carewebqi-portal-access.
- Effective March 4, 2013 all PARs and revisions processed by the Colorado PAR Program must be submitted using CWQI. After April 1, 2013, PARs submitted via fax or mail will not be entered into CWQI and subsequently not reviewed for medical necessity.
- DME questions should be directed to Xerox at: 303-534-0279 or 800-237-0757. Only policy questions regarding Durable Medical Equipment should be directed to the state at 303-866-2687.
- Medications given in a hospital, doctor's office or dialysis unit are to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion.

Drug	Criteria	PAR Length
ACETAMINOPHEN CONTAINING PRODUCTS	A prior authorization is required for dosages of acetaminophen containing products over 4000mg/day of acetaminophen.	N/A Doses over 4000mg/day are not qualified for emergency 3 day supply PA
ACNE PRODUCTS Topical Tretinoin Products and Isotretinoin Products	Prior authorization is required for all topical tretinoin and isotretinoin products. Payment for topical tretinoin therapy and isotretinoin products will be authorized for the following diagnoses: Cystic acne, disorders of Keratinization, psoriasis, neoplasms, comedonal or acne vulgaris. ➢ *Cystic acne, disorders of Keratinization, psoriasis, or neoplasms*, do **not** require previous trials and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for a one-year period. ➢ The diagnosis of *comedonal* does **not** require previous trial and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for an initial three-month period. IF topical tretinoin therapy is effective after the initial approval period, a prior authorization will be granted for a one-year period. ➢ A diagnosis of *acne vulgaris* **requires** previous trials and treatment failures on antibiotic and /or topical treatments. If criteria are met, a prior authorization will be granted for a one-year period. **Quantity limit:** Duac Convenience kit is 1 unit (kit) per 30 days Aldara is 12 packets per 28 days	**See criteria**
ADOXA TT AND CK KIT	A prior authorization will only be approved if a member has tried and failed on the generic oral doxycycline or topical clindamycin for a period of 3 or more months in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
ALBUMIN	Must have an FDA approved indication and given in the member's home or in a long-term care facility for approval. The following are FDA approved indications: ➢ Hypoproteinemia ➢ Burns ➢ Shock due to: ▪ Burns ▪ Trauma ▪ Surgery ▪ Infection ➢ Erythrocyte resuspension ➢ Acute nephrosis ➢ Renal dialysis ➢ Hyperbilirubinemia ➢ Erythroblastosis fetalis	One year
ALLERGY EXTRACT PRODUCTS-Oral (Grastek, Oralair, Ragwitek)	***Grastek (Timothy grass pollen allergen extract)*** Must be between 5 and 65 years old. Must not be pregnant or nursing. Must be prescribed by an allergist.	One year

	Must have a documented diagnosis to ONLY timothy grass pollen allergen extract or the Pooideae family (meadow fescue, orchard, perennial rye, Kentucky blue, and red top grasses) confirmed by positive skin test or IgE antibodies. Must have tried and failed allergy shots for reasons other than needle phobia. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Must be willing to administer epinephrine in case of severe allergic reaction. Must take first dose in physician's office. Must be started 12 weeks prior to the season if giving only seasonally. May be taken daily for up to 3 consecutive years. Must NOT have: • Severe, unstable or uncontrolled asthma • Had an allergic reaction in the past that included trouble breathing, dizziness or fainting, rapid or weak heartbeat • Ever had difficulty with breathing due to swelling of the throat or upper airway after using any sublingual immunotherapy before • Been diagnosed with eosinophilic esophagitis • Allergic to any of the inactive ingredients contained in Grastek which include gelatin, mannitol, and sodium hydroxide • A medical condition that may reduce the ability to survive a serious allergic reaction including but not limited to: markedly compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, and uncontrolled hypertension. • Taking medications that can potentiate or inhibit the effect of epinephrine including but not limited to: beta-adrenergic blockers, alpha-adrenergic blockers, ergot alkaloids, tricyclic antidepressants, levothyroxine, monoamine oxidase inhibitors, certain antihistamines, cardiac glycosides, and diuretics. • Be taken with other immunotherapy (oral or injectable) ***Oralair (Sweet Vernal, Orchard, Perennial Rye, Timothy, Kentucky Blue Grass mixed pollens allergen extract)*** Must be between 10 and 65 years old. Must not be pregnant or nursing. Must be prescribed by an allergist. Must have a documented diagnosis to ONLY Sweet Vernal, Orchard, Perennial Rye, Timothy, or Kentucky Blue Grass allergen extract confirmed by positive skin test or IgE antibodies. Must have tried and failed allergy shots for reasons other than needle phobia. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Must be willing to administer epinephrine in case of severe allergic reaction. Must take first dose in physician's office. Must NOT have: • Severe, unstable or uncontrolled asthma • Had an allergic reaction in the past that included trouble breathing, dizziness or fainting, rapid or weak heartbeat • Ever had difficulty with breathing due to swelling of the throat or upper airway after using any sublingual immunotherapy before • Been diagnosed with eosinophilic esophagitis	

	• Allergic to any of the inactive ingredients contained in Oralair which include mannitol, microcrystalline cellulose, croscarmellose sodium, colloidal anhydrous silica, magnesium stearate, and lactose monohydrate. • A medical condition that may reduce the ability to survive a serious allergic reaction including but not limited to: markedly compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, and uncontrolled hypertension. • Taking medications that can potentiate or inhibit the effect of epinephrine including but not limited to: beta-adrenergic blockers, alpha-adrenergic blockers, ergot alkaloids, tricyclic antidepressants, levothyroxine, monoamine oxidase inhibitors, certain antihistamines, cardiac glycosides, and diuretics. • Be taken with other immunotherapy (oral or injectable) ***Ragwitek (short ragweed pollen allergen extract)*** Must be between 18 and 65 years old. Must be started 12 weeks prior to the season and only prescribed seasonally. Must not be pregnant or nursing. Must be prescribed by an allergist. Must have a documented diagnosis to ONLY short ragweed pollen allergen extract or the Ambrosia family (giant, false, and western ragweed) confirmed by positive skin test or IgE antibodies. Must have tried and failed allergy shots for reasons other than needle phobia. Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interaction. Must be willing to administer epinephrine in case of a severe allergic reaction. Must take first dose in physician's office. Must NOT have: • Severe, unstable or uncontrolled asthma • Had an allergic reaction in the past that included trouble breathing, dizziness or fainting, rapid or weak heartbeat • Ever had difficulty with breathing due to swelling of the throat or upper airway after using any sublingual immunotherapy before • Been diagnosed with eosinophilic esophagitis • Allergic to any of the inactive ingredients contained in Ragwitek which include gelatin, mannitol, and sodium hydroxide • A medical condition that may reduce the ability to survive a serious allergic reaction including but not limited to: markedly compromised lung function, unstable angina, recent myocardial infarction, significant arrhythmia, and uncontrolled hypertension. • Taking medications that can potentiate or inhibit the effect of epinephrine including but not limited to: beta-adrenergic blockers, alpha-adrenergic blockers, ergot alkaloids, tricyclic antidepressants, levothyroxine, monoamine oxidase inhibitors, certain antihistamines, cardiac glycosides, and diuretics. • Be taken with other immunotherapy (oral or injectable)	
ALPHA –1 PROTEINASE INHIBITORS **Aralast, Prolastin and Zemaira**	FDA approved indication if given in the member's home or in a long-term care facility: ➢ Aralast: Chronic augmentation therapy in members having congenital deficiency of Alpha –1 Proteinase Inhibitor with clinically evident emphysema	Lifetime

	➢ Prolastin: Emphysema associated with Alpha-1 Antitrypsin Deficiency ➢ Zemaira: Chronic augmentation and maintenance therapy in members with Alpha- 1 Proteinase Inhibitor deficiency with clinically evident emphysema	
ALZHEIMER'S AGENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
ANOREXIENTS (Diet Pills)	Belviq (lorcaserin) Contrave (naltrexone/bupropion) Qsymia (phentermine/topiramate ER) Xenical (Orlistat)	Weight loss drugs are not a covered benefit.
ANTI-ANEMIA DRUGS (Oral and injectable drugs)	FDA approved indication: Iron Deficiency Anemia Injectable Drugs [i.e.: Infed (iron dextran), Venofer, Ferrlecit] ➢ Diagnosis of iron deficiency anemia when oral preparations are ineffective or cannot be used. Must be administered in a member's home or in a long-term care facility.	Lifetime
ANTICOAGULANTS - ORAL	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
ANTIDEPRESSANTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products. See additional information for citalopram.	One year
ANTIEMETICS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
ANTIHERPETICS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
ANTIHISTAMINES WITH DECONGESTANTS (Rx)	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
ANTIHYPERTENSIVES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
ANTIPLATELETS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
ATYPICAL ANTIPSYCHOTICS (Injectable) Abilify, Invega Sustenna, Geodon and Risperdal Consta, Zyprexa Relprevv	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a member's home. Oral atypical antipsychotic criteria can be found on the Preferred Drug List.	One year
ATYPICAL ANTIPSYCHOTICS (oral)	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products. See additional information for Seroquel (quetiapine).	Two years grandfathering or one year
BACTROBAN (mupirocin) Nasal Cream and Ointment (Generic Bactroban Ointment does not require a prior authorization)	**Bactroban Cream** (mupirocin calcium cream) must be prescribed for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm^2 in total area), impetigo, infected eczema or folliculitis caused by susceptible strains of Staphylococcus aureus and Streptococcus pyogenes. **Bactroban Nasal Ointment** (mupirocin calcium) must be prescribed for the eradication of nasal colonization with methicillin-resistant Staphylococcus	Cream: One year

	aureus in adult patients and health care workers as part of a comprehensive infection control program to reduce the risk of infection among patients at high risk of methicillin-resistant S. aureus infection during institutional outbreaks of infections with this pathogen.	Nasal Ointment: Lifetime
BARBITURATES Medicare-Medicaid enrollees	Barbiturates will require prior authorization for all Medicaid members. Beginning on January 1, 2013, the Colorado Medicaid Program will no longer be allowed to cover barbiturates for Medicare-Medicaid enrollees (dual-eligible members) if they are to be used in the treatment of epilepsy, cancer, or a chronic mental health disorder. Prior authorization will be approved for dual-eligible members for use in sedation, treatment of insomnia, tension headache, muscle contraction headache and treatment of raised intracranial pressure. All other uses will require manual review. For Medicaid primary members, barbiturates will be approved for use in epilepsy, cancer, chronic mental health disorder, sedation, treatment of insomnia, tension headache, muscle contraction headache and treatment of raised intracranial pressure. All other uses will require manual review. For Phenobarbital see the section titled Phenobarbital.	One year
BENLYSTA (belimumab)	A prior authorization may be approved only when documentation has been received indicating that the drug is being administered in the member's home or long-term care facility. The member must also meet the following criteria: • Diagnosis of autoantibody positive SLE with organ involvement; AND • Incomplete response to standard therapy from at least two of the following therapeutic classes: antimalarials, immunosuppressants and glucocorticoids; AND • Maintenance of standard therapy while on BENLYSTA.	One year
BENZODIAZEPINES Medicare-Medicaid enrollees	Benzodiazepines will no longer be a Medicaid benefit for Medicare-Medicaid enrollees (dual-eligible members). The claims are no longer excluded from Medicare part D coverage, and thus must be billed to Medicare part D. The Colorado Medicaid Program will no longer be allowed to cover these medications beginning on January 1, 2013. Coverage will remain in effect for Medicaid primary members.	One year
BISPHOSPHONATES (Injectable) Didronel, Boniva, Aredia, Miacalcin, Zemplar, Hectorol, Zometa, Pamidronate, and Ganite	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a member's home.	One year
BISPHOSPHONATES (oral)	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
BLOOD PRODUCTS	FDA approved indications if given in the member's home or in a long-term care facility: ➢ Plasma protein fraction; shock due to burns, trauma, surgery; hypoproteinemia; adult respiratory distress syndrome; cardiopulmonary bypass; liver failure; renal dialysis; or hemophilia.	Lifetime
BOTULINUM TOXIN	Botox, Myobloc, Xeomin, Dysport If given in the member's home or in a long-term care facility. ➢ *Cervical or Facial Dystonia* ***Not approved for Cosmetic Purposes***	One year
BRAND NAME MEDICATIONS	Only brand name drugs that have a generically equivalent drug (as determined by the FDA) require a prior authorization. Exceptions to the rule include: ➢ The brand name drug has been exempted (see the list below)	One year

	➢ When the reimbursement for a brand-name drug is less expensive than the cost of the generic equivalent ➢ **The physician is of an opinion that a transition to the generic equivalent of a brand-name drug would be unacceptably disruptive to the patient's stabilized drug regimen** ➢ **The patient is started on a generic drug but is unable to continue treatment on the generic drug as determined by the patient's physician** The following list of drug classes is exempt from the generic mandate rule (no PA is required). Medications used for the treatment of: ➢ Biologically based mental illness defined in 10-16-104 (5.5) C.R.S. ➢ Cancer ➢ Epilepsy ➢ HIV/AIDS	
BUTALBITAL-CONTAINING PRODUCTS Quantity limits	Effective August 1, 2014, products containing butalbital are limited to 180 units in 30 days. For members receiving more than 180 tablets in 30 days, these claims will be escalated to the Department for individual review. Please note that if more than one agent is used, the combined total utilization may not exceed 180 units in 30 days.	Case by case
CERDELGA (eligulstat)	Cerdela will be approved if all the following criteria are met: • Member has a diagnosis of Gaucher disease type 1 **AND** • Documentation has been provided to the Department that the member is a CYP2D6 extensive, intermediate, or poor metabolizer as detected by an FDA cleared test **AND** • Members who are CYP2D6 intermediate or poor metabolizers are not taking a strong CYP3A inhibitor (e.g, indinavir, nelfinavir, ritonavir, saquinavir, suboxone, erythromycin, clarithromycin, telithromycin, posaconazole, itraconazole, ketoconazole, nefazodone) **AND** • Members who are CYP2D6 extensive or intermediate metabolizers are not receiving strong or moderate CYP2D6 inhibitors (e.g, sertraline, duloxetine, quinidine, paroxetine, fluoxetine, buproprion, terbinafine) **AND** a strong or moderate CYP3A inhibitor (e.g, indinavir, nelfinavir, ritonavir, saquinavir, suboxone, erythromycin, clarithromycin, telithromycin, posaconazole, itraconazole, ketoconazole, fluconazole, nefazodone, verapamil, diltiazem) Quantity Limits: Max 60 tablets/30 days	One year
CIALIS (tadalafil)	Cialis will be approved for members with a documented diagnosis of BPH who have failed a trial of finasteride (at least 3 months in duration) AND either a trial of a nonselective alpha blocker (therapeutic dose for at least two months) OR a trial of tamsulosin (therapeutic dose for at least one month). Documentation of BPH diagnosis will require BOTH of the following: 1. AUA Prostate Symptom Score ≥ 8 AND 2. Results of a digital rectal exam. Cialis will not be approved for any patient continuing alpha-blocker therapy as this combination is contraindicated in this population. Doses exceeding 5mg per day of Cialis will not be approved.	One year
CITALOPRAM (high dose)	Prior authorization will be required for doses exceeding 40mg/day. Please see the FDA guidance at: http://fda.gov/Drugs/DrugSafety/ucm269086.htm for important safety information.	One year

<table>
<tr><td>COLCRYS (colchicine)</td><td>Quantity Limits:
Chronic hyperuricemia/gout prophylaxis: 60 tablets per 30 days
Familial Mediterranean Fever:120 tablets per 30 days</td><td>One year</td></tr>
<tr><td>COUGH AND COLD (Rx)</td><td>Member <21 years: covered benefit. A prior authorization is not needed.
Member ≥ 21 years must have diagnosis of a chronic condition such as COPD or asthma.</td><td>One year</td></tr>
<tr><td>COX-2 INHIBITORS

Celebrex (celecoxib) brand and generic</td><td>PA is required for members who are 64 years of age and younger. Members over the age of 65 do not require a PA.
A PA will be approved if the COX-2 is prescribed for a FDA approved indication.
<table>
<tr><th>FDA Approved Indication</th><th>Dose and Length of PA</th></tr>
<tr><td>Acute Pain</td><td>Up to 600mg day 1; 200mg BID for no more than 30 days</td></tr>
<tr><td>Dysmenorrhea</td><td>Up to 600mg day 1; 200mg BID. One year approval</td></tr>
<tr><td>Ankylosing spondylitis</td><td>200mg daily; after 6 weeks of 200mg daily dosing if member's condition has been unresponsive, 400mg daily may be approved. Lifetime approval</td></tr>
<tr><td>Familial Adenomatous Polyposis</td><td>400mg BID. Lifetime approval</td></tr>
<tr><td>Osteoarthritis</td><td>200mg daily; 100mg BID. Lifetime approval</td></tr>
<tr><td>Rheumatoid Arthritis</td><td>100-200mg BID. Lifetime approval</td></tr>
<tr><td>Juvenile Rheumatoid Arthritis</td><td>Up to 100mg BID. 6 month approval</td></tr>
</table></td><td>See chart</td></tr>
<tr><td>DESI DRUGS</td><td>DESI drugs (Drugs designated by the Food and Drug Administration as Less Than Effective Drug Efficacy Study Implementation medications) are not a covered benefit.</td><td>None</td></tr>
<tr><td>DIABETES MANAGEMENT CLASSES</td><td>This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.</td><td>One year</td></tr>
<tr><td>DIFICID (fidoxomicin)</td><td>Dificid will be approved if all the following criteria are met:
The indicated diagnosis (including any applicable labs and/or tests) and medication usage must be supported by documentation from the patient's medical records AND
Prescriber must be a gastroenterologist or an infectious disease specialist AND
Diagnosed with Clostridium difficile-associated diarrhea AND
≥ 18years of age AND
Failed at least a 10 day treatment course with oral metronidazole AND oral vancomycin OR
Allergy and/or intolerance to both metronidazole and vancomycin
Quantity limits:
Dificid: Max 20 tabs/30 days</td><td>10 days</td></tr>
<tr><td>ELESTRIN GEL (estradiol)</td><td>A prior authorization will only be approved if a member has tried and failed on generic oral estradiol therapy and diagnosed with moderate-to-severe vasomotor symptoms (hot flashes) associated with menopause. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</td><td>One year</td></tr>
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EPANED (enalapril)	Epaned will be approved for members under the age of 5 years who cannot swallow a whole or crushed tablet.	One year
ERECTILE DYSFUNCTION DRUGS Caverject Cialis Edex Levitra Muse Viagra	These drugs are not a covered benefit. Yohimbine: PAs can no longer be approved for erectile dysfunction. Any PAs for use as a mydriatic agent or a vasodilator (not related to erectile dysfunction) may be approved.	Not available Not qualified for emergency 3 day supply PA ---------- Lifetime
ERYTHROPOIESIS STIMULATING AGENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
ESBRIET (Pirenidone)	Esbriet will be approved if all the following criteria are met: • Member has been diagnosed with idiopathic pulmonary fibrosis AND • Is being prescribed by or in conjunction with a pulmonologist AND • Member is 18 years or older AND • Member has baseline ALT, AST, and bilirubin prior to starting therapy AND • Member does not have severe (Child Pugh C) hepatic impairment, severe renal impairment (Crcl<30 ml/min), or end stage renal disease requiring dialysis AND • Female members of reproductive potential must have been counseled regarding risk to the fetus AND • Member is not receiving a strong CYP1A2 inducer (e.g, carbamazepine, phenytoin, rifampin)	One year
FENTANYL PREPARATIONS Short acting Actiq, Fentora, Onsolis Long acting Duragesic Transdermal System	Actiq, Fentora and Onsolis: Approval will be granted if the member is diagnosed with terminal illness and has already received and is tolerant to opioid drugs for the cancer pain. The PA may be granted for up to 4 lozenges, tablets or soluble films per day. Duragesic Transdermal System: A PA is required for doses of more than 1 Patch/2 Days. For all Fentanyl preparations: If the patient is in hospice and palliative care, the PA will be automatically granted regardless of the number of doses prescribed.	One year
FIBROMYALGIA AGENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
FILGRASTIM/ PEGFILGRASTIM / SARGRAMOSTIM Neupogen, Neulasta and Leukine	Prior authorization is required for therapy with filgrastim, pegfilgrastim or sargramostim. **Prior authorizations for PEGFILGRASTIM will be approved for the following indication if the criterion is met:** Indication: To decrease the incidence of infection due to neutropenia in members receiving myelosuppresive anti-cancer therapy. ➢ Criterion 1. CBC and platelet count obtained before chemotherapy is administered.	One year

	Prior authorizations will be approved for FILGRASTIM AND SARGRAMOSTIM for the following indications if the applicable criteria are met: Indication: To decrease the incidence of infection due to severe neutropenia caused by myelosuppresive anti-cancer therapy. ➢ Criterion 1. Either the post nadir ANC is less than 10,000 cells/mm^3 or the risk of neutropenia for the member is calculated to be greater than 20% ➢ Criterion 2. Routine CBC and platelet counts twice weekly Indication: Use in patients undergoing bone marrow transplant and for use after bone marrow transplant. ➢ Criterion 1. Routine CBC and platelet counts at least three times weekly for filgrastim and two times weekly for sargramostim. Indication: For patients undergoing peripheral blood progenitor cell collection and therapy. ➢ Criterion 1. Monitoring of neutrophil counts after four days of treatment. Indication: For filgrastim only, for chronic administration to reduce the incidence and duration of members with congenital neutropenia, cyclic neutropenia or idiopathic neutropenia. ➢ Criterion 1. CBC and platelet count obtained before treatment with filgrastim begins. ➢ Criterion 2. Routine CBC and platelet counts twice weekly during initial four weeks of therapy and during the two weeks following any dose adjustment. Indication: To decrease the incidence of infection due to severe neutropenia in HIV/AIDS members. ➢ Criterion 1. Evidence of neutropenia Infection exists or ANC is below 750 cells/mm^3 ➢ Criterion 2. ANC is maintained at Approximately 1,000 cells/mm^3 by filgrastim adjustment ➢ Criterion 3. Routine CBC and platelet counts as needed.	
FIBROMYALGIA	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
FLECTOR 1.3% PATCH (diclofenac)	A prior authorization will only be approved if a member has tried and failed on Voltaren Gel. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
FLUORIDE PREPARATIONS	A prior authorization will not be needed for members less than 21 years of age. For members 21 years old or older, approval will be granted if using well water or otherwise living in an under fluorinated area according to the CDC at http://apps.nccd.cdc.gov/MWF/CountyDataV.asp?State=CO. Other situations will require a letter of necessity and will be individually reviewed.	One year
FLUOROQUINOLONES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
FUZEON (enfuvirtide)	If administered in the physician's office or delivered to physician's office, physician must bill as a medical claim on the 1500 claim form **(no PA required).** If administered in the member's home or in a long-term care facility, a prior authorization is required and must meet the criteria below for approval	Six months

	Based on clinical trial data, ENF should be used as part of an *optimized* background regimen for treatment-experienced members: ➢ For treatment-experienced members with evidence of HIV-1 replication, treatment should include at least one antiretroviral agent with demonstrated HIV-1 susceptibility on the basis of genotypic/phenotypic *resistance* assays, and *two* "active" antiretroviral agents. o Members must have limited treatment options among currently commercially available agents. ➢ Members must be 18 years of age or older with advanced HIV-1 infection, and not responding to approved antiretroviral therapy. ➢ Members must have a CD4 lymphocyte count less than 100 cells/mm3 and a viral load greater than 10,000 copies/ml (measurement within the last 90 days). Past adherence must be demonstrated based on: ➢ Attendance at scheduled appointments, and/or ➢ Prior antiretroviral regimen adherence, and/or ➢ Utilization data from pharmacy showing member's use of medications as prescribed ➢ Ability to reconstitute and self-administer ENF therapy. At 24 weeks, members must experience at least ≥ 1 $\log_{10}$ decrease in HIV RNA or have HIV RNA below quantifiable limits to continue treatment with ENF. Members are not eligible if antiretroviral treatment-naive and/or infected with HIV-2. Pre-approval is necessary Practitioner must either be Board Certified in Infectious Disease, or be an HIV experienced practitioner. Verification must be produced with the prior approval documents. **These guidelines may be modified on the basis of other payer formularies and/or the emergence of new data.**	
GATTEX (teduglutide)	Prior authorization will be approved if all of the following criteria are met: • Member is 18 years of age or older; • Member has documented short bowel syndrome; • Member is dependent on parenteral nutrition for twelve consecutive months; • The prescribing physician is a gastroenterologist; and • Medical necessity documentation has been received and approved by Colorado Medicaid clinical staff (please fax to 303-866-3590 attn: Clinical Pharmacy Staff) • The initial prior authorization will be limited to a two month supply.	Two months initially; may be approved by State for up to one year
GROWTH HORMONES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
H2 BLOCKERS **Ranitidine capsules and liquid**	**Generic H2 Blockers** do not require a PA except for ranitidine capsules and liquid. Ranitidine capsules: Require the prescribing provider to certify that capsules are "medically necessary" and that the member cannot use the tablets.	One year

	Ranitidine liquid: A prior authorization will be granted for members with a feeding tube or who have difficulty swallowing. A prior authorization is not required for children under 12 years of age.	
HEPATITIS C VIRUS TREATMENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
HETLIOZ (tasimelteon)	**HETLIOZ®** will be approved for members who meet the following criteria: • Have a documented diagnosis of non-24-hour sleep wake disorder (non-24 or N24) by a sleep specialist AND • Member is completely blind	One year
Homozygous Familial Hypercholesterolemia (HoFH)	**Juxtapid (lomitapide)** Prior authorization will be approved if all of the following criteria are met: • Member is 18 years of age or older; • Member has documented diagnosis of homozygous familial hypercholesterolemia (HoFH); • Member has failed therapy with high dose statin therapy (e.g. atorvastatin 40mg or higher, Crestor 20mg or higher) • The prescribing physician is enrolled in the Juxtapid REMS program. **Kynamro (mipomersen)** will be approved for members meeting all of the following criteria: • Confirmed diagnosis of homozygous familial hypercholesterolemia (HoFH) as determined by either a or b a. Laboratory tests confirming diagnosis of HoFH: LDLR DNA Sequence Analysis OR LDLR Deletion/Duplication Analysis for large gene rearrangement testing---only if the Sequence Analysis is negative OR APOB and dPCSK9 testing if both of the above tests are negative but a strong clinical picture exists. b. Documentation is received confirming a clinical or laboratory diagnosis of HoFH • Has a history of therapeutic failure, contraindication, or intolerance to high dose statin therapy or cholesterol absorption inhibitor (ezetimibe or bile acid resin) AND • Is being prescribed by a physician specializing in metabolic lipid disorders AND • The prescriber is enrolled in the REMS program AND • Is not being used as monotherapy AND • Has baseline liver function (AST,ALT, ALK,, and total bilirubin) AND Does not have moderate or severe hepatic impairment or active liver disease.	One year
HORIZANT (gabapentil enacarbil)	A prior authorization may be approved for members meeting all of the following criteria: • Diagnosis of Restless Leg Syndrome; • Therapy failure on at least a one month trial of Mirapex (pramipexole) and Requip (ropirinole); • Incomplete therapeutic response to generic gabapentin. A maximum of one tablet per day will be approved.	One year
HORMONE THERAPY	**Depo Provera (medroxyprogesterone)/Lunelle (estradiol cipionate/medroxyprogesterone)** FDA approved indication if given in a long-term care facility or in the members home:	One year

	• Females: Contraception, uterine bleeding, amenorrhea, endometrial cancer • Males: Sexual aggression / Pedophilia – Only Depo-Provera will be approved • Not approved for administration in the physician's office – these must be billed through medical. **Implanon (etonogestrel)** See PHYSICIAN ADMINISTERED DRUGS. Not a covered pharmacy benefit when implanted in the clinic or hospital outpatient center. **Nexplanon (etonogestrel)** • See PHYSICIAN ADMINISTERED DRUGS. Not a covered pharmacy benefit when implanted in the clinic or hospital outpatient center.	
INSULIN	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
INTRANASAL CORTICOSTEROIDS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
IVIG	Members must have one of the following conditions: ➢ Immunodeficiency disorders: 2. Common Variable Immunodeficiency (CVID) 3. Severe Combined Immunodeficiency (SCID) 4. X-Linked Agammaglobulinemia 5. X-Linked with Hyperimmunoglobulin M (IgM) Immunodeficiency 6. Wiskott-Aldrich Syndrome 7. Pediatric Human Immunodeficiency Virus (HIV): ▪ Members are less than 13 years of age and CD-4 Count is > 200/mm3 ➢ Neurological disorders: 1. Guillain-Barre' Syndrome 2.Relapsing-Remitting Multiple Sclerosis 3.Chronic Inflammatory Demyelinating Polyneuropathy 4.Myasthenia Gravis 5.Polymyositis and Dermatomyositis ➢ Chronic Lymphocytic Leukemia (CLL) ➢ Autoimmune Neutropenia (AN): 1.Absolute neutrophil count is less than 800 mm And 2.Has recurrent bacterial infections ➢ Autoimmune Hemolytic Anemia (AHA) ➢ Liver or Intestinal Transplant ➢ Idiopathic Thrombocytopenic Purpura (ITP): 1. Preoperatively for members undergoing elective splenectomy with platelet count < 20,000 2. Members with active bleeding & platelet count <30,000. 3. Pregnant women with platelet counts <10,000 in the third trimester. 4. Pregnant women with platelet count 10,000 to 30,000 who are bleeding.	One year One year CLL: One year AN: 6 months AHA: 5 weeks ITP: 5 days
KALYDECO (ivacaftor)	Kalydeco will only be approved if all of the following criteria are met: 1. Member has been diagnosed with cystic fibrosis AND 2. Member is an adult or pediatric patient 6 years of age or older AND	One year

	3. Documentation has been provided to indicate one of the following gene mutation: in the CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P,S549N, or S549R.* AND 4. Documentation has been provided that baseline ALT and AST have been accessed and are within 2x normal limits (AST and ALT should be examined every 3 months for the first year and annually after that). * If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. Kalydeco will only be approved at doses no more than 150 mg twice daily. Prior Authorizations need to be obtained yearly. Kalydeco will not be approved for members who are concurrently receiving rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's Wort.	
LEUKOTRIENES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
LHRH/GnRH Luteinizing Hormone Releasing Hormone/Gonadtropin Releasing Hormone	Must be given in the member's home or in a long-term care facility. Prior authorization will be granted for FDA Approved Indications Only: ➢ **Eligard:** Palliative-treatment of Advanced Prostate Cancer ➢ **Lupron (leuprolide):** Prostate Cancer, Endometriosis, Uterine Leiomyomata (fibroids), Precocious Puberty Lupron will be approved for Gender Identity Dysphoria based on the following criteria: • The member has a diagnosis of Gender Identity Dysphoria which is made by a mental health professional with experience in treating gender dysphoria. Where available, the mental health professional should ideally have training in child and adolescent developmental psychology AND • The member should have at least 6 months of counseling and psychometric testing for gender identity prior to initiation of Lupron AND • The prescribing provider has training in puberty suppression using a gonadotropin releasing hormone agonist AND • Lupron may not be started until girls and boys exhibit physical changes of puberty (confirmed by levels of estradiol and testosterone, respectively) and no earlier than Tanner stages 2-3 (bilateral breast budding or doubling to tripling testicular size to 4-8 cc). • Duration of treatment: Lupron will be covered to a maximum of 16 years of age for Gender Identity Dysphoria. ➢ **Trelstar**: Palliative treatment of Advanced Prostate Cancer ➢ **Viadur:** Palliative treatment of Advanced Prostate Cancer ➢ **Vantas**: Palliative treatment of Advanced Prostate Cancer ➢ **Zoladex**: Breast Cancer, Endometriosis, Endometrial Thinning, Prostate Cancer	One year 16 years of age
LIPIDS/AMINO ACIDS/PLASMA PROTEINS	Approval will be given if administered in the member's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	Lifetime

MAKENA Hydroxyprogesterone caproate injection	Makena will be approved for members that meet the following criteria • The drug is being administered in the home or in long-term care setting; • Member has a Singleton pregnancy and a history of singleton spontaneous preterm birth; • Therapy is being initiated between 16 weeks gestation and 20 weeks, 6 days gestation. • Continue through 36 weeks 6 days gestation or delivery; whichever occurs first. • Dose is administered by a healthcare professional.	See criteria
MOXATAG (amoxicillin)	A prior authorization will only be approved if a member is allergic to inactive ingredients in immediate release amoxicillin.	One year
MULTIPLE SCLEROSIS AGENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products. **Quantity limit** for Copaxone 20mg: 30 units per 30 days	One year
NEWLY APPROVED PRODUCTS	Newly marketed drugs may be subject to prior authorization for a minimum of nine months following FDA marketing approval. Initial approval criteria will include non-preferred criteria (for drugs within a reviewed PDL class); or FDA approved indications, dose, age and place in therapy. For drugs in PDL classes, the next class annual review will include the new agent. For non-PDL drugs, criteria shall be reviewed at the quarterly DUR meeting closest to the nine month minimum.	One year
OFEV (Nintedanib)	Ofev will be approved if all the following criteria are met: • Member has been diagnosed with idiopathic pulmonary fibrosis AND • Is being prescribed by or in conjunction with a pulmonologist AND • Member is 18 years or older AND • Member has baseline ALT, AST, and bilirubin prior to starting therapy AND • Member does not have moderate (Child Pugh B) or severe (Child Pugh C) hepatic impairment AND • Female members of reproductive potential must have been counseled regarding risk to the fetus and to avoid becoming pregnant while receiving treatment with Ofev and to use adequate contraception during treatment and at least 3 months after the last dose of Ofev AND • Member is not taking a P-gp or CYP3A4 inducer (e.g, rifampin, carbamazepine, phenytoin, St. John's Wort) Quantity Limits: 60 tablets/30 days	One year
ONFI (clobazam)	ONFI® will be approved for members who meet the following criteria: 1. Member is ≥ 2 years of age AND 2. Has a documented diagnosis of seizure AND 3. Is being prescribed by or in conjunction with a neurologist AND 4. Has failed a one month trial with three anticonvulsants (Failure is defined as: lack of efficacy, allergy, intolerable side effects, or significant drug-drug interactions) OR 5. Is receiving Stiripentol AND 6. Is not being used as monotherapy	1 year
OPIOID AGONIST/ANTAGONIST	**Revia (naltrexone)** - A PA is not required. **Bunavail** will be reviewed on a case by case basis until criteria are developed.	1 year

	Evzio will be reviewed on a case by case basis until criteria are developed. **Suboxone** will be approved if the following criteria are met: • The prescriber is authorized by the manufacturer to prescribe Suboxone • The member has an opioid dependency • The member is not currently receiving an opioid or opioid combination product. • Will not be approved for the treatment of pain. • Opioid claims will not be allowed for members with a claim for Suboxone in the preceding 30 days. • will not be approved for more than 24mg of buprenorphine /day **Subutex** will be approved if all of the following criteria are met: • The prescriber is authorized by the manufacturer to prescribe Subutex • The member has an opioid dependency • The member is pregnant or the member is allergic to Naloxone • Subutex will not be approved for the treatment of pain. • Subutex will not be approved for more than 24mg/day **Vivitrol** • Approval will be given if administered in the member's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense. **Zubsolv** • Approval will be granted if prescriber meets the qualification criteria under Drug Additional Treatment Act (DATA) of 2000 and has been issued a unique DEA identification number by the DEA, indicating that he or she is qualified under the DATA to prescribe Subutex or Suboxone AND • The member has a diagnosis of opioid dependence AND • The member is 16 years of age or older AND • No claims data show concomitant use of opiates in the preceding 30 days AND • The member must have tried and failed, intolerant to, or has a contraindication to generic buprenorphine/naloxone SL tablets.	
OPHTHALMIC ALLERGY PRODUCTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
OPIOIDS Long Acting – Oral Opioids	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
ORACEA (doxycycline)	A prior authorization will only be approved if all of the following criteria are met: ➢ member has taken generic doxycycline for a minimum of three months and failed therapy in the last 6 months (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions), ➢ member has been diagnosed with rosacea with inflammatory lesions, and ➢ member is 18 years of age or older	16 weeks

ORAL OPIOIDS- SHORT ACTING	**Short acting opioids** will be limited to a total of 120 tablets per 30 days per member. Exceptions will be made for members with a diagnosis of a terminal illness (hospice or palliative care) or sickle cell anemia. For members who are receiving more than 120 tablets currently and who do not have a qualifying exemption diagnosis, a 6 month prior authorization can be granted via the prior authorization process for providers to taper members. Please note that if more than one agent is used, the combined total utilization may not exceed 120 units in 30 days. Information regarding tapering, morphine equivalents, other therapies and other resources can be found on the Department website at: https://www.colorado.gov/hcpf/provider-forms. **Acute Pain: Beginning 8/25/2014: If a member has an acute pain situation, and is prescribed more than 4 tablets per day, the pharmacy may enter diagnosis code 338.1 on the claim to receive an immediate override. Please note that the override will be available for acute pain indications only.** Prior authorization will still be required for more than 120 tablets per 30 days. The Department will monitor the utilization of the diagnosis code to assure it is being used to override daily limits for cases of acute pain indications only. The pharmacy or prescriber may also still call 1-800-365-4944 and request a prior authorization for acute pain. Examples of acute pain situations are post-operative surgery (including dental), fractures, shingles, and a car accident. This is not an all-inclusive list.	Chronic pain: 6 months to allow for the tapering of a member down to the limit of 120 units per 30 days Acute pain: one time override per claim
OTC PRODUCTS	Medical Necessity ➢ Aspirin, Insulin and Plan B are covered without a PA ➢ Prilosec OTC: *See Proton Pump Inhibitor's section* ➢ Guaifenesin 600mg LA is covered for members having an abnormal amount of sputum ➢ Quinine Sulfate *is no longer covered* for leg cramps ➢ Herbal products are not a benefit except for cranberry tablets, which are covered for urinary tract infections ➢ Diabetic needles and supplies are not a prescription benefit and should be billed as supply ➢ Broncho saline is not covered- refer to Sodium Chloride section ➢ Cough and Cold Products must have a diagnosis of a chronic respiratory condition for which these medications may be prescribed or otherwise be medically necessary ➢ Antihistamine (w/ decongestant) must have a diagnosis of seasonal or perennial allergic rhinitis or chronic sinusitis or otherwise be medically necessary ➢ Nicomide is approved for acne *Nursing Facilities: Please provide OTC floor stock list.* *Members with Erythema Bullosum (EB) can receive any OTC medication with a prior authorization.*	One year
OTEZLA (apremilast)	Otezla will be approved for treatment of psoriatic arthritis or plaque psoriasis in members who have had treatment failure with at least one conventional DMARD (e.g, methotrexate, leflunomide, and sulfasalazine), Enbrel and Humira (Failure is defined as: lack of efficacy of a 3 month trial, allergy, intolerable side effects or significant drug-drug interaction.).	One year
OVERACTIVE BLADDER AGENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
OXSORALEN (methoxsalen)	Approval will be granted with diagnosis of: Myosis; Fungoides; Psoriasis or Vitiligo	One year

PANCREATIC ENZYMES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
PHENOBARBITAL	Phenobarbital will be approved for neonatal narcotic abstinence syndrome based on the following criteria: • The member has a diagnosis of non-opiate or polysubstance abuse **OR** • The member has first failed methadone for the diagnosis of opiate withdrawal **AND** • Serum phenobarbital levels are being monitored. Max duration: 3 months	Max 3 months
PHYSICIAN ADMINISTERED DRUGS	Medications given in a hospital, doctor's office or dialysis unit are only to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion following prior authorization approval. Prior authorizations will be approved based upon documentation of the location for administration.	
PROCYSBI (cysteamine)	Approval will be granted if the member is 6 years of age or older **AND** Has a diagnosis of nephropathic cystinosis **AND** documentation is provided to the Department that treatment with cysteamine IR (Cystagon®) was ineffective, not tolerated, or is contraindicated.	One year
PROMETHAZINE	A Prior authorization is required for all routes of administration for members under the age of two. Children under the age of two should not use Promethazine. Promethazine is contraindicated in such patients because of the potential for fatal respiratory depression.	One year Not qualified for emergency 3 day supply PA
PROPECIA (finasteride)	***Not covered for hair loss***	One year Not qualified for emergency 3 day supply PA
PROTON PUMP INHIBITORS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
PULMONARY ARTERIAL HYPERTENSION THERAPIES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
RAVICTI (glycerol phenylbutyrate)	Ravicti will only be approved for members meeting the following criteria: • Member must be 2 years of age or older • Member must have a documented diagnosis of urea cycle disorder (UCD) • Member must be on a dietary protein restriction (verified by supporting documentation) • Member must have tried and failed Buphenyl as evidenced by uncontrolled hyperammonia over the past 365 days • Medication must be prescribed by a physician experienced in the management of UCD (e.g., geneticist)	One year
REBATE DISPUTE DRUGS	Medical necessity.	One year Not qualified for emergency 3 day supply PA

REQUIP XL (pramipexole)	A prior authorization will only be approved if a member has tried and failed on generic immediate release ropinirole for a period of 3 or more months in the last 6 months and the member has a diagnosis of Parkinson's disease. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Grandfathering:** Members who have been previously stabilized on Requip XL can receive approval to continue on the medication for one year if medically necessary.	One year
REVIA (naltrexone)	Please see opioid agonist/antagonist.	N/A
RESPIRATORY INHALANTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
SANDOSTATIN (octreotide)	Approved for: acromegaly; carcinoid tumors; and vasoactive intestinal peptide tumors.	Lifetime
SEDATIVE/HYPNOTICS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
SILENOR (doxepin)	A prior authorization will be approved if a member meets one of the following criteria: • Contraindication to preferred oral sedative hypnotics (Lunesta, zaleplon and zolpidem) • Medical necessity for doxepin dose < 10 mg • Age greater than 65 years old or hepatic impairment (3 mg dose will be approved if this criteria is met)	One year
SIMVASTATIN 80mg	Simvastatin 80mg dose products will only be covered for members who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in members who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication entitled, "FDA Drug Safety Communication: New restrictions, contraindications, and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.	One year
SKELETAL MUSCLE RELAXANTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
SMOKING CESSATION (Rx & OTC)	Members should be referred to the QuitLine or another behavior modification program. The name of that program should be included on the prior authorization form. Medical Assistance Program will pay for only **one product** at a time but a member may receive multiple strengths of a product or multiple products during the two 90-day paid benefit periods.	Two 90-day paid benefits per year Not qualified for emergency 3 day supply PA
SODIUM CHLORIDE For inhalation use	Broncho Saline is **not** covered as a drug benefit. **Sodium Chloride 0.9%:** Only the 3cc unit dose is covered, if the member is sight-impaired and used in the member's home. **Sodium Chloride 3% and 7% vial:** Nebulizer treatment for members with cystic fibrosis and other pulmonary diseases for mucolytic therapy done in the home. All other requests for sodium chloride (inhalation use) must be billed through medical.	Lifetime
SOLARAZE 3% GEL (diclofenac sodium)	A prior authorization will only be approved if the member has a diagnosis of Actinic Keratoses (AK).	One year

STADOL (butorphanol) nasal spray	Quantity limit: 10mg/ml 2.5ml bottle limit of 4 bottles (10ml) per 30 days	One year
STATINS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
STIMULANTS and OTHER ADHD AGENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
SUBOXONE and SUBUTEX	Please refer to Opioid Agonist/Antagonist	
SYNAGIS (Palivizumab)	**Pharmacy Prior Authorization requests for Synagis® must be submitted by fax or phone using the Synagis® Prior Authorization Form found at https://www.colorado.gov/hcpf/provider-forms. Medical PAs must be submitted through coloradopar.com. Synagis season will begin December 1, 2014 and end April 30, 2015. PARs may be requested beginning November 17, 2014.** **Key Points** 1. No more than 5 doses per season. 5 doses provide more than 6 months of protective serum concentration. 2. Synagis® is not recommended for controlling outbreaks of health care-associated disease. 3. Synagis® is not recommend for prevention of health care-associated RSV disease. 4. Infants born later in the season may require less than 5 doses to complete therapy to the end of the season. 5. Monthly prophylaxis should be discontinued in any child who experiences a breakthrough RSV hospitalization. 6. Synagis® is not recommended to prevent wheezing, nosocomial disease, or treatment of RSV 7. Synagis® is not routinely recommended for patients with a diagnosis of Down syndrome unless they also have a qualifying indication listed below. 8. In the **first year of life** Synagis® is recommended: a. For infants born before 29w 0d gestation. b. For infants born before 32w 0d **AND** with CLD of prematurity **AND** requirements of >21% oxygen for at least 28 days after birth. c. For infants with hemodynamically significant heart disease (acyanotic heart disease who are receiving medication to control CHF and will require cardiac surgical procedures **AND** infants with moderate to severe pulmonary hypertension**) AND** born within 12 months of onset of the RSV season. d. Children who undergo cardiac transplantation during the RSV season. e. For infants with cyanotic heart defects AND in consultation with a pediatric cardiologist AND requirements of >21% oxygen for at least 28 days after birth AND continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy) f. If an infant has neuromuscular disease or pulmonary abnormality AND is unable to clear secretions from the upper airways g. A child who will be profoundly immunocompromised during the RSV season (solid organ or hematopoietic stem cell transplantation, receiving chemotherapy)	Maximum of 5 doses per season

	h. An infant with cystic fibrosis with clinical evidence of CLD AND/OR nutritional compromise 9. In the **second year of life** Synagis® is recommended for: a. Infants born before 32w 0d **AND** with CLD of prematurity **AND** requirements of >21% oxygen for at least 28 days after birth **AND** continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy) b. A child who will be profoundly immunocompromised during the RSV season (solid organ or hematopoietic stem cell transplantation, receiving chemotherapy) c. Infants with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities of chest radiography or chest computed tomography that persist when stable) **OR** weight for length less than the 10th percentile. d. Children who undergo cardiac transplantation during the RSV season.	
TARGETED IMMUNE MODULATORS (iv infused products)	Orencia (abatacept) – will be approved for members who are receiving the infusion in their home or in long-term care and who meet one of the following: ➢ Members with moderate to severe rheumatoid arthritis who have failed therapy with both Enbrel and Humira ➢ Members with moderate to severe juvenile idiopathic arthritis Remicade (infliximab) will be approved for members who are receiving the infusion in their home or in long-term care and who meet one of the following: ➢ members with ulcerative colitis ➢ members with rheumatoid arthritis who have tried and failed therapy with both Enbrel and Humira ➢ members with psoriatic arthritis ➢ members with ankylosing spondylitis ➢ members with juvenile idiopathic arthritis ➢ members with plaque psoriasis ➢ members with Crohn's Disease Rituxan (rituximab) - will be approved for members who are receiving the infusion in their home or in long-term care and who meet one of the following: ➢ Members with moderate to severe rheumatoid arthritis who have tried and failed both Enbrel and Humira ➢ Members with Chronic Lymphocytic Leukemia ➢ Members with Non-Hodgkins Lymphoma	One year
TARGETED IMMUNE MODULATORS (self-administered)	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
TESTOSTERONE PRODUCTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
THROMBOLYTIC ENZYMES	Approved for **IV Catheter Clearance or Occluded AV Cannula** if given in member's home or long term care facility.	One year
TOPICAL IMMUNOMODULATORS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
TORADOL (ketorolac)	**Quantity limit:** 5 days of therapy for every 30 days = 20 tablets per 30 days	
TPN PRODUCTS	Approval will be given if administered in the member's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	Lifetime

TRAMADOL	Tramadol is not approved for more than 400mg/day. **Rybix ODT** Rybix will be approved for members who are unable to swallow oral tablets or for members who are unable to absorb oral medications (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Ryzolt** A prior authorization will only be approved if a member has tried and failed on the maximum dose of tramadol (400mg per day) for a period of 3 or more months in the last six months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Ultram ER (tramadol ER)** A prior authorization will only be approved if a member has tried and failed on the maximum dose of tramadol (400mg per day) for a period of 3 or more months in the last six months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug	One year
TRIPTANS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at https://www.colorado.gov/hcpf/provider-forms for the Preferred Products.	One year
VACCINES Flu, Hepatitis B and Pneumonia	H1N1 vaccine is a covered benefit. All other vaccines must be bill on Colorado 1500 form as a medical expense unless administered in long-term care facility. Any vaccine can be approved by prior authorization if a member is living in a long-term care facility. (Not a covered benefit for regular patients – only long-term care facilities).	One year Not qualified for emergency 3 day supply PA
VERIPRED (prednisolone)	A prior authorization will only be approved if a member has tried and failed on a generic prednisolone product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
VERSED (Midazolam)	Approved if given in the member's home or in a long-term care facility and given for: ➢ Preoperative sedation or anesthesia ➢ Terminally ill members with Cancer ➢ Member with Erythema Bullosum (EB) –approval for one year	One month
VERSED Midazolam injection used as nasal spray	Midazolam injection used as a nasal inhalation will be approved for members who meet the following criteria: 1. Member is ≥ 6 months of age AND 2. Has a diagnosis of seizure disorder AND 3. Is prescribed by or in conjunction with a Neurologist AND 4. Treatment dose does not exceed 10mg Dosing Limits: 10 vials/month Only MIDAZOLAM 5mg/ml (for doses ≤ 5mg) and 10mg/2ml vials (for doses > 5 mg) will be covered.	One year
VIMOVO (naproxen/esomeprazole magnesium)	Approved if member has failed treatment with two Preferred Proton Pump Inhibitors within the last 24 months, and has one of the following diagnoses: ➢ Ankylosing spondylitis in patients at increased risk of developing NSAID induced ulcers; ➢ Osteoarthritis in patients at increased risk of developing NSAID induced ulcers; ➢ Rheumatoid arthritis in patients at increased risk of developing NSAID induced ulcers.	One year

VITAMINS (Rx)	**Prescription Vitamins (except for prenatals) will be authorized for:** ➢ ESRD, CRF, renal insufficiency, diabetic neuropathy or renal transplant ➢ Members under the age of 21 with a diagnosis disease that prohibits the nutrition absorption process as a secondary effect of the disease. ➢ Members with Erythema Bullosum (EB) Hydroxocobalamin Injections In addition to the above general vitamin criteria, approval can also be given for methylmalonic academia (MMA). Cyanocobalamin Injections In addition to the above general vitamin criteria, approval can also be given for vitamin B12 deficiency. Folic Acid Vitamins (exceptions exist for Folic Acid 1mg, see below) In addition to the above general vitamin criteria, approval can also be given for folic acid vitamins if one of the following criteria is met: ➢ Currently taking Methotrexate or Alimta ➢ A diagnosis of folic acid deficiency (megaloblastic and macrocytic anemia are the most common). Some drugs or other conditions may cause deficiency -- Approval will be granted for these indications IF the member has current folic acid deficiency and documented by the provider. ➢ For Female Members: Approval will be granted for the prevention of a neural tube defect pregnancy and for the prevention of miscarriages. ➢ Homocysteinemia ➢ Sickle cell disease Cyanocobalamin/Folic Acid/Pyridoxine In addition to the above general vitamin criteria, approval can also be given for members: ➢ with Homocysteinemia or Homocystinuria ➢ on dialysis ➢ with or at risk for cardiovascular disease **L-methylfolate** approved for depressed members who are currently taking antidepressants and are partial or non-responders **Metanx** approved for members with non-healing diabetic wounds **Prenatal Vitamins** are a regular benefit for all female members. Prenatal vitamins are not covered for male members. **Folic Acid 1mg** does not require a prior authorization for female members. **Prescription Vitamin D and Vitamin K products** do not require a prior authorization.	One year
VIVITROL	Please refer to Opioid Agonist/Antagonist	
VUSION OINTMENT (miconazole/zinc oxide/white petrolatum)	A prior authorization will only be approved if a member has failed on an OTC antifungal **and** a generic prescription antifungal. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
XOLAIR (omalizumab)	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility. Medications administered in a physician's office must be billed as a medical expense.	One year

	Because this medication has a Black Box warning requiring the administration under the supervision of a physician, a PA will not be approved if administered in a member's home.	
ZUBSOLV	Please refer to Opioid Agonist/Antagonist	